U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 04 June 2004

Case No. : 2003-BLA-5834

In the Matter of:

JAMES H. FELDMEIER,
Claimant

v.

PEABODY COAL COMPANY,
Employer

OLD REPUBLIC INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Robert S. Peppiatt, Esq.
For the Claimant

Scott A. White, Esq.
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by James H. Feldmeier for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended ("Act"). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

[1] The Director, OWCP, was not represented at the hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of persons who were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung.

A formal hearing in this case was held in Evansville, Indiana, on February 20, 2004. Each of the parties was afforded full opportunity to present evidence and argument at the hearing as provided in the Act and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

The findings and conclusions that follow are based upon my observation of the appearance and the demeanor of the witness who testified at the hearing, and upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. Statement of the Case

The Claimant, James H. Feldmeier, filed a claim for black lung benefits pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, on May 7, 2001 (DX 1).[2] A Notice of Claim was issued on May 24, 2001, identifying Peabody Coal Co., as the putative responsible operator (DX 16). On June 1, 2001, the Employer filed its Response to Notice of Claim (DX 17), and on June 6, 2001, the Employer filed its Controversion to the claim (DX 18). The District Director, OWCP, made an initial determination of entitlement with benefits commencing May 1, 2001 (DX 24). The Employer requested a formal hearing and the claim was referred to the Office of Administrative Law Judges on May 13, 2002 (DX 31).

A hearing was held in Evansville, Indiana, on February 20, 2004, before the undersigned Administrative Law Judge. The record was held open for 60 days for the filing of briefs (Tr. 31).

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits and "Tr." refers to the transcript of the February 20, 2004 hearing.

In its brief, the Employer argues that all of its 34 submitted exhibits should be considered in the determination of this case. Prior to the applicability of the amended regulations at 20 C.F.R. Part 725 (2001), evidence was generally admissible in black lung claims without restrictions so long as the due process rights of the parties were protected, *i.e.*, the parties had notice and an opportunity to be heard on the evidence presented. In evaluating voluminous evidence, however, "there is a point of diminishing returns and a point at which additional evidence provides almost no value." *Underwood v. Elkay Mining, Inc.*, 105 F.3d 946 (4th Cir. 1997). It is the "quality" of the evidence that should be properly weighed, not the quantity submitted. *Id.*

The amended regulations at § 725.414 contain specific restrictions on the admission of medical evidence. The provisions at § 725.456 state that "[m]edical evidence in excess of the limitations contained in § 725.414 shall not be admitted into the hearing record in the absence of good cause." Twenty C.F.R. § 725.456(b)(1) (2001). The Employer argues that it compiled medical evidence to be used in an earlier claim which was withdrawn by the Claimant, and that it continued to produce evidence while the new regulations were in abeyance and the evidentiary rules were not clear. (Employer's Closing Argument, p. 39). It argues that good cause exists for any excess evidence developed as the Employer acted in good faith in initially developing the evidence.

The Employer offers no case law supporting its position, and I find none that would justify a "good faith" exception to the evidentiary limitations. The regulations are clear and specific on what evidence is now permissible in a new regulations claim. The Employer submitted a Black Lung Benefits Act Evidence Summary Form which conforms to the new regulations. The evidence designated on that form will be considered in this Decision.

II. Issues

The controverted issues as listed on Form CM-1025 are as follows:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled;

4. Whether the Miner's disability is due to pneumoconiosis; and,

5. The remaining issues set forth in paragraph 18, as listed in DX 17, 18, 20, 22, & 26.

III. Findings of Fact and Conclusions of Law

The Claimant, James H. Feldmeier, was born on May 28, 1948 (DX 1). He completed the 12th grade (DX 1). The Claimant has two dependents for purposes of augmentation of benefits; namely, his wife, Mary C. (Kissel) Feldmeier, whom he married on April 11, 1997 (DX 5), and one child, Skyler T. Feldmeier, who was born on January 15, 1998 (DX 36).

The Claimant testified that he started smoking cigarettes as a teenager and currently smokes a small amount. He estimated a smoking history of 15-17 years at a rate of about one-half pack per day (Tr. 23). Dr. Cohen noted a smoking history of 15 years at a rate of one-half pack of cigarettes per day (DX 35). Dr. Selby noted a smoking history of a maximum of one pack of cigarettes per day starting at age 18, currently one-half pack per day. He stated that he quit on several occasions (EX 3). Dr. Houser noted a 30+ year history at a rate of one pack of cigarettes per day starting in 1966 (age 18) and currently a few cigarettes per day (DX 8). These smoking histories were given by the Claimant to each physician. I find that the Claimant started smoking at the age of 18 as stated by Drs. Selby and Houser and by the Claimant in his testimony. I find that the Claimant generally smoked at the rate of one pack per day, for a total smoking history of 30 years at a rate of one pack of cigarettes per day, and continues to smoke.

Coal Mine Employment

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to determine the beginning and ending dates of coal mine employment by using any credible evidence.

On his application, the Claimant stated that he worked in coal mine employment for 32 years (DX 2). At the hearing, the parties stipulated to 32 years of coal mine employment (Tr. 9).

The Claimant's Employment History form lists coal mine employment with Peabody Coal Co. from 1968 to 1999 (DX 2). The Claimant's FICA earnings worksheet shows employment with Peabody Coal Co. from 1968-2000 (DX 4). A Black Lung Claim Employment

Inquiry was submitted by Peabody Coal Co. listing employment by the Claimant from September 23, 1968 through October 23, 1999, with an additional year of disability (DX 19). I find that the Claimant has established 32 years of coal mine employment. On his Employment History, the Claimant stated that over the relevant period he was a surface coal miner (DX 2).

The Claimant's last employment was in the State of Indiana; therefore, the law of the Seventh Circuit is controlling.

Responsible Operator

Peabody Coal Co. does not challenge its designation as responsible operator, and I find that Peabody Coal Co. is properly named as responsible operator pursuant to §§ 725.494, 725.495.

IV. Medical Evidence

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standard
1.	8/13/02	DX 35	Cohen B reader[3]	1/0 p/q	Fair
2.	8/13/02	EX 11	Wiot B reader Board cert.[4]	0/0	Fair/dark
	Comments:	No evidence of coal workers' pneumoconiosis; blebs at both apices; chest otherwise unremarkable.			
3.	12/13/01	EX 18	Wiot B reader Board cert.	0/0	Good

[3] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2).

[4] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202(a)(ii)(C).

Comments: No evidence of coal workers' pneumoconiosis; bullae present at both apices; chest otherwise unremarkable.

4.	10/01/01	DX 14	Sargent B reader Board cert.	Quality only	Poor
5.	10/01/01	DX 13	Whitehead B reader Board cert.	1/1 p/q	Fair
6.	10/01/01	EX 4	Wiot B reader Board cert.	0/0	Fair

Comments: No evidence of coal workers' pneumoconiosis; old granulomatous disease at extreme left apex; chest otherwise unremarkable.

7.	10/01/01	EX 5	Spitz B reader Board cert.	0/0	Fair

Comments: Lungs clear; no pleural disease.

Pulmonary Function Studies

	Date	Exh.	Doctor	Age/Hgt.[5]	FEV_1	MVV	FVC	Standards
1.	8/13/02	DX 35	Cohen	54/74"	2.25	84	3.83	Tracings included/ Good coop./ comp.
2.	12/1/98	DX 15	Carandang	50/75" Post-Bronch.	2.83 2.62	60 63	4.48 4.16	Tracings included/ coop./comp. not noted
3.	12/13/01	EX 3	Selby	53/ 75" Post-Bronch.	1.18 1.20	N/A N/A	2.46 2.05	Tracings included. Poor coop./ comp.

[5] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find the Miner's height to be 75".

4.	10/01/01	DX 10	Houser[6]	53/75"	1.40	N/A	2.29	Tracings included/ Good coop./ comp.
				Post-Bronch.	1.45	N/A	2.06	

Arterial Blood Gas Studies

	Date	Exhibit	Physician	pCO_2	pO_2
1.	8/13/02	DX 35	Cohen	37.8	75.5
			Exercise	38.2	82.2
2.	12/13/01	EX 3	Selby	43.2	72.4
			Exercise	41.4	78.5
3.	10/01/01	DX 9	Houser	40.7	68.5
			Exercise	39.5	82.3

Narrative Medical Evidence

Section 725.414(a)(3)(i) specifies that a responsible operator may submit no more than two medical reports as part of its affirmative case. Additionally, "any chest x-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report and physicians' opinions that appear in a medical report *must each be admissible under this paragraph or paragraph (a)(4)* of this section." Section 725.414(a)(3)(i) (emphasis added). Section 725.414 (a)(4) permits the introduction of hospitalization records for a respiratory or pulmonary or related disease.

On its evidence designation form, the Employer/Responsible Operator designated the medical reports of Dr. Tuteur (EX 1) and Dr. Selby (EX 3). The report of Dr. Tuteur is based upon medical reports from Drs. Henry and Barnett and on multiple pulmonary function studies and x-ray interpretations not admissible in the record pursuant to § 725.414(a)(3)(i). It is not possible to identify any portion of Dr. Tuteur's medical report that is solely based on admissible medical evidence. Therefore, I exclude the July 8, 2002 medical report of Dr. Tuteur.

1. Dr. Jeff W. Selby, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and a B reader,

[6] Dr. Houser invalidated this test as it did not meet ATS quality standards, and opined that the data collected was unreportable.

examined the Claimant and submitted a December 13, 2001 written report (EX 3). Based on symptomatology (shortness of breath), employment history (32 years), individual and family histories (emphysema, hernia, arthritis, irritable colon), smoking history (average one pack per day since age 18 (35 years)), physical examination (chest good symmetrical expansion with good airflow, good breath sounds, few low-pitched rhonchi), chest x-ray (0/1), pulmonary function study (invalid, poor cooperation), CT scan (no evidence of interstitial lung disease), EKG (slight leftward axis, otherwise normal), and arterial blood gas study (slight hypoxemia at rest, normalization with exercise), Dr. Selby diagnosed no pneumoconiosis or any respiratory condition, impairment, or defect as a result of coal mine employment, coal mine dust exposure, or coal mine dust inhalation. He opined that Mr. Feldmeier retains the respiratory and pulmonary capacity to perform his last coal mine job as oiler on the dragline. He opined that the Miner suffers from some bullous emphysema secondary to smoke inhalation. He opined that shortness of breath was due to being "out of shape" and untreated bronchial asthma unrelated to coal mine employment.

2. Dr. Harold B. Spitz, a Board-certified Radiologist and a B reader, interpreted a December 13, 2001 CT scan (EX 17). Dr. Spitz opined that the CT scan showed no evidence of coal workers' pneumoconiosis.

3. Dr. Jerome F. Wiot, a Board-certified Radiologist and a B reader, interpreted a December 13, 2001 CT scan (EX 18). "The CT scan shows no evidence of coal workers' pneumoconiosis …. There are prominent bullae present bilaterally … the CT is otherwise unremarkable."

4. Dr. Robert Cohen examined the Claimant on September 27, 2002 (DX 35). Based on symptomatology (cough, wheezing, dyspnea), employment history, individual and family histories (mother - diabetes), smoking history (one-half pack cigarettes, 15 years), physical examination (difficulty breathing, prolonged expiration and wheezing throughout both lung fields), chest x-ray (1/0), pulmonary function study (moderate obstructive defect), arterial blood gas study (mild hypoxemia), and an EKG (normal), Dr. Cohen diagnosed coal workers' pneumoconiosis. He based his diagnosis on employment history, pulmonary function results, symptoms, and chest x-ray. He listed the etiology of these conditions as "more than 30 years of coal mine employment and his 7.5 pack years of tobacco smoke exposure." Dr. Cohen opined that the Miner's chronic respiratory condition was mostly due to coal mine employment as the Miner had only a "minimal exposure to tobacco smoke." Noting that the Miner's FEV_1 reading was only 52% of predicted,

and comparing that against the exertional requirements of his previous coal mine job, Dr. Cohen opined that the Claimant is totally disabled from his pulmonary disease.

5. Dr. William Houser examined the Claimant on October 1, 2001, and submitted a written report (DX 8). Based on symptomatology (sputum, wheezing, dyspnea, cough, hemoptysis), employment history, individual and family histories (frequent colds, pneumonia, wheezing, chronic bronchitis, arthritis), smoking history (since 1966, generally one ppd of cigarettes), physical examination (lungs normal, no wheeze, rhonchi, rales), chest x-ray (1/1), pulmonary function study (severe reduction in FVC and FEV_1, post-bronchodilator values normal), and arterial blood gas study (mild hypoxemia), Dr. Houser diagnosed coal workers' pneumoconiosis based upon chest x-ray and 33 years of coal dust exposure, and chronic obstructive pulmonary disease caused by cigarette smoking and exposure to coal and rock dust from coal mine employment. He opined that the Miner suffers from a mild impairment, as evidenced by normal exercise performance with submaximal effort and normal post-exercise arterial blood gas readings.

V. Discussion and Applicable Law

The Claimant filed his black lung benefits claim on May 7, 2001 (DX 1). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.[7]

In order to establish entitlement to benefits in a living miner's claim pursuant to 20 C.F.R. § 718, the claimant must establish that he suffers from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. *See* 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6th Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. The record contains six interpretations of three different chest x-

[7] Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of § 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

rays. Dr. Sargent reviewed the October 1, 2001 x-ray film for quality only and rated the film as "poor."

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp., Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993).

The August 13, 2002 x-ray was read as negative by Dr. Wiot, a Board-certified Radiologist and a B reader, and as positive by Dr. Cohen, a B reader. I give greater weight to the reading by Dr. Wiot, who holds greater qualifications, and find that the August 13, 2002 x-ray evidence is negative for pneumoconiosis.

The December 13, 2001 x-ray was read as negative by Dr. Wiot, a dually certified physician. I find that the December 13, 2001 x-ray evidence is negative for pneumoconiosis.

The October 1, 2001 x-ray was read as positive by Dr. Whitehead, a Board-certified Radiologist and a B reader, and as negative by Drs. Wiot and Spitz, who are also dually qualified physicians. I give more weight to the combined interpretations of Drs. Wiot and Spitz and find that the October 1, 2001 x-ray evidence is negative for pneumoconiosis.

Having found each of the x-rays of record to be negative, I find that the existence of pneumoconiosis has not been established pursuant to 20 C.F.R. § 718.202(a)(1).

Section 718.202(a)(2) is inapplicable because there are no biopsy or autopsy results. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions

in the lungs. Section 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6th Cir. 1985). Further, a medical report may be

rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *See Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Selby, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and a B reader, opined that the Miner did not suffer from pneumoconiosis or any respiratory condition, impairment, or defect as a result of coal mine employment. He based that diagnosis on a negative chest x-ray, normal lung function upon physical examination, negative CT scan, and normal arterial blood gas readings with exercise. Dr. Selby's report is well reasoned. He utilized the objective testing data to support his diagnosis of no pneumoconiosis or any respiratory condition. Noting Dr. Selby's superior credentials, I afford his opinion substantial weight.

Dr. Spitz, a Board-certified Radiologist and a B reader, interpreted a CT scan and opined that the scan reviewed showed no signs of pneumoconiosis. The Department of Labor has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). Therefore, a CT scan, while arguably the most sophisticated and sensitive test available, must still be measured and weighed based upon the radiological qualifications of the reviewing physician. *Consolidation Coal Co. v. Director, OWCP [Stein],* 294 F.3d 885 (7th Cir. 2002). Dr. Spitz is a dually certified physician. I afford Dr. Spitz's interpretation great weight.

Dr. Wiot, A Board-certified Radiologist and a B reader, interpreted a CT scan and opined that the scan showed no evidence of pneumoconiosis. Noting the superior credentials of Dr. Wiot when measuring and weighing this evidence (*see Stein*, above), I afford Dr. Wiot's CT scan interpretation substantial great weight.

Dr. Cohen diagnosed coal workers' pneumoconiosis. He based that determination on employment history, pulmonary function results, symptoms, and chest x-ray. The x-ray evidence has been determined to be negative for pneumoconiosis. The Board has held that pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981). Dr. Cohen makes reference to the Miner's 30+ years of coal mine employment, but fails to explain how the nature or quantity of coal dust exposure fits into his diagnosis. He also incorrectly states the Miner's smoking history at 15 years, one-half pack per day, when I have found a smoking history of 30 years at one pack per day. Finally, while

Dr. Cohen ties the Miner's symptoms to pneumoconiosis, Dr. Selby, a Board-certified Pulmonologist, opined that the Miner's symptoms were caused by smoke inhalation, emphysema, untreated bronchial asthma, and by the Miner being "out of shape."

A reasoned opinion is one in which the Administrative Law Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19 (1987). Dr. Cohen's documentation does not adequately support his diagnosis. I afford his opinion less weight.

Dr. Houser, who lists no medical specialty credentials, diagnosed coal workers' pneumoconiosis based upon chest x-ray and 33 years of coal dust exposure, and he diagnosed chronic obstructive pulmonary disease caused by cigarette smoke and coal dust exposure.

Dr. Houser's coal workers' pneumoconiosis diagnosis is not well reasoned. His positive x-ray interpretation has been refuted by more qualified physicians. Further, Dr. Houser's diagnosis of coal workers' pneumoconiosis is based upon his own reading of a chest x-ray and the Claimant's history of dust exposure. In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical judgment under § 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone does not tend to establish that he does [or does] not have any respiratory disease arising out of coal mine employment. *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion merely a reading of an x-ray and not a reasoned medical opinion. *Id.* As Dr. Houser fails to state any other reasons for his diagnosis of coal workers' pneumoconiosis beyond the x-ray and exposure history, I find his coal workers' pneumoconiosis diagnosis neither well reasoned nor well documented.

Dr. Houser also diagnosed chronic obstructive pulmonary disease caused by cigarette smoking and coal dust exposure. Such a chronic disease of the lungs fits within the legal definition of pneumoconiosis. Dr. Houser's diagnosis of legal pneumoconiosis is not well reasoned. Dr. Houser failed to explain how a chronic lung condition coincided with physical examination showing normal lung functions. He bases his diagnosis on coal dust exposure but fails to discuss how he reached that determination. He noted poor pulmonary function readings, but invalidated his own test as not meeting the quality standards. Noting Dr. Houser's lack of medical specialty credentials, I afford his opinion less weight.

Taken as a whole, Dr. Selby, a Pulmonary Specialist and a B reader, provides a well-reasoned opinion, based upon objective medical evidence, that the Claimant does not suffer from pneumoconiosis as defined in § 718.201. This opinion is bolstered by the negative CT scan readings of Drs. Wiot and Spitz, both Board-certified Radiologists and B readers. I find that the opinion of Dr. Selby outweighs the opinions of Drs. Cohen and Houser. Accordingly, I find that the Claimant has not established the existence of pneumoconiosis under § 718.202(a)(4).

Causal Connection Between Pneumoconiosis and Coal Mine Work

Because the Claimant has not established pneumoconiosis, the question of whether it is caused by his coal mine employment is moot. Moreover, even though the evidence establishes more than 10 years of coal mine work, any presumption of a causal connection with coal mine employment is more than adequately rebutted by the medical opinion evidence discussed above. Therefore, the evidence fails to establish this element of the claim.

Total Disability

Since the Miner does not have pneumoconiosis, his claim cannot succeed. In any event, had he established the existence of the disease, the evidence does not show that he had a totally disabling respiratory or pulmonary ailment which could be attributed to pneumoconiosis. Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i) and (ii). The Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *See, e.g., Jewell Smokeless Coal Corp. v. Street*,

42 F.3d 241 (4th Cir. 1994). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 test results are divided by the FVC test results.

The record contains four pulmonary function studies. Dr. Houser invalidated his October 1, 2001 test as not meeting the quality guidelines. The December 13, 2001 test was based upon poor effort and cooperation, and as such, I find it to be invalid. *See Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984) (little or no weight may be accorded to a ventilatory study where the miner exhibited "poor" cooperation or comprehension). The December 1, 1998 study produced nonqualifying readings. The August 13, 2002 study produced qualifying readings. More weight may be accorded to the results of a recent ventilatory study over the results of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). I find that the August 13, 2002, pulmonary function study is supportive of total disability.

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The record contains three arterial blood gas studies. All arterial blood gas testing results are nonqualifying.

There is no evidence presented, nor do the parties contend that the Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

Under § 718.204(b)(2)(iv) total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work. There are three medical narratives in the record discussing the Claimant's impairment level.

Dr. Selby, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and a B reader, opined that the Miner retains the respiratory and pulmonary capacity to perform his last coal mine job as an oiler on the drag line. He based that opinion on physical examination observations, negative chest x-rays, and CT scans, and on arterial blood gas readings that normalized with exercise. Dr. Selby noted that pulmonary function testing was invalid and offered no support of total disability. Dr. Selby used objective testing to opine that while the Miner suffered from some emphysema and from being out of shape, the objective testing showed sufficient respiratory and pulmonary capacity to return to his previous coal mine job. I find Dr. Selby's opinion to be supported by the record. Noting Dr. Selby's superior credentials, I afford his opinion substantial weight.

Dr. Cohen compared pulmonary function test results and physical examination observations to the exertional requirements of the Miner's last coal mine job to opine that the Claimant is totally disabled by his pulmonary disease. Dr. Cohen used the objective data to support his opinion that the Miner suffers from total pulmonary disability. I have previously held that the Miner did not suffer from pneumoconiosis. While his opinion is entitled to some weight, I find that it does not support a finding of disability due to pneumoconiosis.

Dr. Houser, who lists no medical specialty credentials, opined that the Miner suffered from only a mild impairment, as evidenced by normal exercise performance with submaximal effort and normal post-exercise arterial blood gas readings. Dr. Houser utilized the objective evidence to diagnose a mild impairment that did not totally disable the Miner from his previous coal mine employment. I find his opinion well reasoned. Noting Dr. Houser's lack of medical specialty credentials, I afford his opinion some weight towards a finding of no total disability.

Taken as a whole, I find that the qualifying pulmonary function testing is outweighed by the normal blood gas testing and the well-reasoned opinions of Drs. Selby and Houser that the Claimant does not suffer from total pulmonary or respiratory disability. Dr. Cohen's opinion, while supporting total disability, does not support total disability due to pneumoconiosis, and I afford his opinion less weight. I find that the Claimant has failed to establish total disability due to pneumoconiosis pursuant to § 718.204(b)(2).

VI. Entitlement

James H. Feldmeier, the Claimant, has not established entitlement to benefits under the Act.

VII. Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claim of James H. Feldmeier for benefits under the Act is hereby DENIED.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.